DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 - 0 0 7

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR 42 Section 447.253

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2003~~ 2004 $ 0
b. FFY ~~2004~~ 2005 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A

10. SUBJECT OF AMENDMENT:
Formatting Adjustments for Attachment 4.19A

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
As per Governor's letter dated Dec 14, 1999

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Marilyn E. Golden

14. TITLE:
Director, Operations and Finance Office

15. DATE SUBMITTED:
June 7, 2004

16. RETURN TO:
Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Trish Bohm

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 9 2004

18. DATE APPROVED: AUG 24 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: Deputy Director, CMSO

23. REMARKS:
Fax and mail Change to block 11 per State's instruction

FORM HCFA-179 (07-92)

Instructions on Back

I. Methods and Standards for Establishing Prospective Payment Rates – Inpatient Hospital Services

A. Payment Methods for Hospitals

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

B. Definitions

1. Diagnosis Related Group (DRG): A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.

   Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

   a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.

   b. Rehabilitation and Specialty-Acute Hospitals: all hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).

   c. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).

   d. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

   Facilities which do not fall into the peer groups described in a. or b. will default to the peer groups described in c. and d. based on geographic location.

5. Medicare Base Rate: The hospital specific Medicare base rate, which will be obtained directly from the Medicare Intermediaries, represents the payment a hospital would receive from Medicare for a DRG with a weight equal to one. The Medicare base rate used for rate setting each State Fiscal Year (July 1 through June 30) will be those effective on each October 1 prior to the beginning of the State Fiscal Year.

6. Disproportionate Share Hospital (DSH) factors: These factors are specific payments made by Medicare to Disproportionate Share Hospitals within the Medicare base rate. The operating and capital Disproportionate Share Hospital factors will be obtained from the Medicare Intermediaries. The operating Disproportionate Share Hospital factor is multiplied by the federal portion of the operating subtotal to get the operating Disproportionate Share Hospital amount. The capital Disproportionate Share Hospital factor is multiplied by the capital portion of the federal payment to get the capital Disproportionate Share Hospital amount.

7. Budget Neutrality: Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The estimated hospital specific payments is calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate.

8. Medicaid Base Rate or Base Rate: An estimated cost per Medicaid discharge.

   For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals, including Rehabilitation and Specialty-Acute Hospitals.

   For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year.

   Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education. The estimated cost per discharge amount for Nursery and Neo-Natal Intensive Care Units will be calculated by multiplying the Medicare hospital specific base rate, without DSH, by the ratio of Medicaid Nursery or Neo-Natal costs to total Nursery or Neo-Natal costs respectively. A cost per discharge amount for Graduate Medical Education will be obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

Pediatric Specialty Hospitals will receive an additional adjustment factor of 1.335 to account for the specialty care provided. This adjustment factor will not be applied to the Medicaid cost add-ons.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be the Medicare TEFRA rate from the most recently audited Medicare/Medicaid cost report (CMS 2552) divided by the Medicaid case mix index and then modified by a set percentage equally for all PPS Rehabilitation and Specialty-Acute Hospitals. The percentage will be the percentage used to modify the Medicare base rate of all other PPS hospitals multiplied by 1.397. The Medicare/Medicaid cost report and Medicaid case mix index used for this calculation will be those available as of March 1 each year.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 60 days prior to any adjustment in the payment. Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Exempt hospitals are those hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system. The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS). Exempt hospitals will be paid a per diem for inpatient hospital services. As of July 1, 2003 free-standing psychiatric facilities shall be the only exempt providers.

10. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94. standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

11. Infant Cost Outlier. To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%, the Medicare rate) rather than to establish a separate cost outlier mechanism.

C. DRG Method of Payment

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point, based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.

2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.

3. When approved outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG payment divided by the average length of stay. The percentage will be determined by the State Agency.

4. All State-operated facilities will be exempt from the DRG-based prospective payment system.

5. Abbreviated patient stays will be paid as follows:

   a. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

b. In cases involving transfers, each hospital involved, excluding rehabilitation and specialty-acute hospitals, will be paid a DRG per diem for each case based upon the full DRG payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.

c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

D. Adjustments To The Payment Formula

1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.

2. In order to continue to meet the Federal Boren Amendment requirements, the information used to calculate each prospective payment system (PPS) facility's cost per discharge will be updated. The following rebasing and payment protocol for payments is established:

a. Effective September 19, 1990, the base rate for each facility shall be calculated based upon the most recently audited cost report available for each facility (as of 12/31/87). Changes made to audited cost reports after the rebasing calculations will not constitute the basis for a provider appeal. Fort the time period between July 1, 1990 and September 18, 1990, those hospital whose base rate increased by 7% or less as a result of the implementation of State Plan Amendment 90-02, should be assured a rate increase of at least 7% (not to exceed their FY 91 payment rate) during this 80 day period (July 1, 1990 to September 18, 1990).

b. Beginning July, 1991, an annual inflator shall be applied to each facility's cost per discharge. This annual inflator shall be derived as follows:

i. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.

ii. The HCFA Hospital Market Basket Index will be compared to the weighted average increase in the cost per discharge for each peer group. The weighted average increase will be determined by comparing the increase in costs from cost reports available for FYE 12/31/88. (In each subsequent fiscal year, the cost reports used for making the comparison shall be rolled forward by one year.)

iii. If the weighted average increase within each peer group in the cost per discharge is greater than the HCFA Hospital Market Basket Index, the difference between the figures will be added to the Market Basket Index to derive the annual inflator.

iv. Under no circumstances shall the annual weighted average increase in cost within any peer group driven by this calculation exceed a 7% limit.

v. The annual inflator is subject to changes in appropriations made by the General Assembly and the annual inflator may be adjusted by the Department accordingly. Prior to the start of the State Fiscal Year providers will receive a letter from the Department describing how the rate, including inflation, was calculated.

c. On the third year (July, 1993) rates shall be calculated based upon the audited cost reports available for each facility for FYE 12/31/90. If the audited cost data show that the annual inflators were too high, or if they show the inflators were too low, the actual cost from the reports available for FYE 12/31/90 shall be used. There shall be NO retrospective changes to the rates if/when the "third year" rebased rates show that the 7% annual inflator was inaccurate.

d. Beginning July, 1993, rates shall be recalculated or rebased every third year and the annual inflator shall be used to increase the rates in the interim years.

e. In rebasing years, the initial base rate for pediatric specialty hospitals will be attributed to the routine, ancillary, capital, and medical education cost centers, proportionally, based on the actual costs from the most recently audited cost report. The cost per discharge for the medical education cost center, which is capped at 100 percent, will be deducted from the initial base rate and the reminder will be attributed to the other three costs centers in proportion to actual costs. These figures, which will add up to the total base rate, will represent the pediatric specialty hospital peer group caps for the routine, ancillary, and capital cost centers. These figures will be used as the starting point for subsequent payment cap adjustments as described in the previous definition of Base Rate.

f. Effective July 1, 2003 all adjustments outlined in number 2. of this section (Adjustments To The Payment Formula) are suspended.

E. Adjustments For Exempt Providers

1. Effective for dates of service after July 1, 1991, exempt hospitals will receive annual modifications to per diem rates. Based on hospital-specific annual projected inpatient cost increases and changes in consumer price index, per diem rate increases or decreases will be authorized subject of a maximum increase of 7% annual limit. Beginning in July, 1993, and for future PPS hospital rebasing periods, the maximum amount of any cost increase granted to an exempt facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for the State fiscal year 1994 and for every year thereafter when PPS hospital base rates are recalculated. In no case, shall the per diem rate granted to an exempt hospital exceed the facility's Medicaid cost per day.

2. Exempt hospitals which are government owned mental health institutes. Effective October 1, 2001, government owned mental health institutes shall receive annual modifications to the per diem rates. The rates shall be established to cover one hundred per cent of the total allowable cost to treat Medicaid clients. These rates shall be based on annual cost reports submitted by the mental health institutes. These cost reports will be subject to annual audits. The audited allowable costs shall be used to set the basis for the retroactive rate which will be effect for the same period covered by the cost report. At the beginning of each cost reporting period, the mental health institute may submit a hospital specific, projected inpatient per diem cost amount which may be used to set an interim rate for the following cost reporting period. The interim rate shall be adjusted to equal the audited allowable per diem cost for the Medicaid clients. This amount is established through audit. The ceilings and cost limit increases specified in paragraph 1 of this section shall not apply to these facilities.

3. Exempt hospitals are eligible for the Major Teaching Hospital and Disproportionate Share Payments.